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THIS JOURNAL IS MANUFACTURED UNDER WARTIME CONDITIONS IN CONFORMITY WITH ALL GOVERNMENT REGULATIONS CONTROLLING THE USE OF PAPER AND OTHER MATERIALS

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ORIENTATION TO STUDIES IN PSYCHOPATHOLOGY

BY OSKAR DIETHELM, M.D.*

In the field of psychopathology, which embraces all pathological variations of the functions of the personality, many divergent investigations are being carried out. It is necessary that these divergent tendencies be related to each other by well-recognized and accepted principles of research. There does not seem to be any justification to consider psychopathology as fundamentally different from pathology. This point has even been disputed by some of those who accept the concept of a psychobiologically integrated personality. The fact that psychodynamic factors are very important, forcing psychiatrists to consider new theories and techniques, does not allow the claim that a new science has been created. The point has also been raised that psychopathology means essentially unusual and disturbing behavior in interpersonal relationships. These relationships and their disturbances are important, but not more so than other functions of the personality and their pathological changes.

The definition of psychopathology is the same as that of pathology; i.e., findings which are unusual in degree, or occur within the wrong age period, are pathological.

Present-day investigations in the field of psychopathology represent the results of the fruitful lives of Kraepelin, Janet, Freud, and Meyer, who, in their turn, made use of contributions of preceding generations and contemporary workers. The application of scientific psychologic methods and of careful description of what can be observed was followed by the development of methods which permitted the study of psychodynamic factors. The relationship of the patient to environment and to physiologic manifestations became included in the psychopathologic realm. At present, psychopathology can be considered to be on a sound foundation, and progress should be more steady than in the past. Dogmatic theories which have from time to time impeded scientific development considerably will become less influential when psychopathology has reached a desirable degree of stability. Most of the workers of today acknowledge that reliable and valid psychologic tests and experiments have to be mastered, that a clear

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description of the facts observed is essential, that psychodynamic investigations should be far-reaching but critically guided and must include personal and environmental factors, that physiologic implications are always present and offer valuable investigative possibilities. Isolated observations are of very limited value. An accumulation of isolated observations on a vast group of patients may appear impressive, but these findings have led to contradictory results and rarely advance psychopathologic knowledge. Tests and experiments should be repeated at different times on the same individual. These rules apply to psychologic and physiologic studies. In order to elucidate the various points made, I shall refer to the work of the group at the Payne Whitney Psychiatric Clinic, including reference to published, as well as yet unpublished, results.

1. PSYCHOLOGIC EXPERIMENTS AND TESTS

Sound psychologic knowledge is necessary to achieve carefully conceived and valid experiments of personality functions. This statement should be self-evident to physicians who demand that physiologic experiments should be founded on sound physiologic knowledge.

Psychologic tests may be used for psychopathologic investigation. However, these tests are frequently too complex and cover too broad a field. The use of intelligence tests is very limited and specific clinical tests should be planned to investigate selected psychopathologic reactions. A perusal of psychiatric literature reveals that far-reaching and generalized conclusions are too readily drawn and that impatience causes physicians to use clinically findings which are still in the investigative stage. Furthermore, the tests are often administered by persons who either may not be satisfactorily trained in the methods of administering the test or are not sufficiently experienced in offering it to psychiatric patients. In psychopathologic investigations, the giving of the test is an experiment in which the course of the experiment as well as the final outcome must be considered.

Psychiatrists have been inclined to recommend the use of tests which do not fulfill the necessary requirements. A brief review of the concepts of reliability and validity and their application to current tests may serve as illustration. Reliability indicates the accuracy with which a test measures a given function and how well it excludes variations in score due to chance errors. Most of the older tests mentioned in psychiatric literature have been advocated without any determination of reliability. Among the tests now in use, Hausmann's Absurdities Tests have so low a variability that the tests cannot be considered reliable. This low reliability is almost certainly related to the small number of units in the tests (M. R. Jones and O. Diethelm). The validity of this test (the ability of the test to measure the function that it is supposed to measure) is also highly questionable. The functions which are to be studied by this test have

not been defined. Conclusions drawn from the findings of this test have been widely accepted and have influenced current concepts of schizophrenic thinking disorders. A critical review of other tests used for psychopathologic studies gives similar discouraging results.

In selecting tests and experiments, it becomes obvious that any thinking disorder, minor as it may be, must be considered. Disorders of thinking may be transient because of emotions which may or may not be related to the experiment. In psychopathologic disorders, one should evaluate carefully whether the patient is able to understand fully the necessary details, to correlate them, and carry out instructions. A varying degree of indecision, which may be due to a considerable number of factors, must be considered. Frequently, patients may be bewildered by the multitude of requirements and by the complexity of the task. Perplexity is a similar reaction, more intense and accompanied by anxiety. In puzzlement, the patient wonders about the meaning of his observations. Emotions, especially anxiety, accompany these reactions and in turn affect the progress of the experiment and its results.

2. PERSONALITY INVESTIGATIONS

In any kind of investigation, one must consider the whole personality; i.e., the individual with a certain endowment at birth, his growth affected by life experiences, and the role which both reality and phantasy play. Although the patient is studied in the present, his attitude to the past, present, and future must be taken into account. Somatic factors are always present. Furthermore, one must inquire into the relationship of the somatic findings to the personality function which is under investigation. The significance of the findings must be evaluated according to the individual physiologic reactions. In the study of leucocytosis, unusual findings were noted in various types of depressions. Further investigation revealed that leucocytosis also occurred in connection with intense anxiety, panic, and resentment. In some individuals, these emotions were not accompanied by leucocytosis but other physiologic changes were noted, e.g., increased fasting sugar. The same psychopathologic reaction may be accompanied by different somatic expressions in different individuals.

The question whether one prefers to remain within an objective-descriptive realm or manipulate dynamic factors depends on the problem which is being studied. The distinction is one of degree. It is essential that any fact observed be described in well-chosen, unequivocal words so that another person can make the same observation and agree or disagree with the conclusions. It is also essential that one recognize and evaluate the constant presence of psychodynamic factors.

The claim that observations should remain on an objective level and that subjective scrutiny should be disregarded cannot be maintained. In the

evaluation of emotions, anxiety for instance, many objective signs are available, but how the subject feels can be described only by him. The observations of the subject are valuable as amplification and may even be made the topic of considerable investigation.

The tendency of clinical investigators to generalize is most unfortunate in present-day psychopathology. Many psychiatrists glibly use words like "anxiety" and "compulsions," finding them in every disorder, and making them the central dynamic and psychopathologic factors. By making terms too inclusive, these authors disregard valuable knowledge acquired in the past, and are thus prevented from noticing obstacles as well as leads, the investigation of which would add to our psychopathologic knowledge. In my own studies, I was able to demonstrate some of the differences between "negativism" and "aversion." In recent years, however, "negativism" has been expanded in the field of child psychiatry to the extent that the original meaning has become entirely obliterated. These observations of "negativism" in children are a valuable addition to our clinical knowledge but should be investigated most carefully and described in clear terms. It must be proved that these observations correspond exactly to "negativism" and it must be established that they express psychologic reactions which are in accord with the psychopathologic reaction of "negativism," and in what way there are similar or identical reactions involved.

The influence of emotions is always present. It is therefore necessary that they be evaluated in the investigation of psychopathologic reactions. One has to single out the various types of emotions, their intensity, and their gradual or sudden development and their duration. One should inquire how the subject experiences the emotion, what the emotion implies to the subject and to the observer, and whether there is a symbolic significance of the emotion. These points are important whether it is principally the emotional reactions or their physiologic influences which are being studied, or the ever-present influence of emotions on other personality functions. The interference of anxiety and resentment with memory functions has been demonstrated in psychoneurotic reactions in patients under 40 years of age and in senile patients (O. Diethelm). In some psychoneurotic patients, a gross disturbance in the functions which enter into reasoning has been observed in the presence of anxiety when it reaches a sufficient degree (L. Welch, L. Long, O. Diethelm). Strong transient anxiety may lead to a disorder of thinking which is expressed in vagueness, a mild degree of illogical thinking, and varying degrees of incoherence. If factors of elation are present, all these symptoms become increased (O. Diethelm). In addition, ability to concentrate and flow of associations may be considerably affected (L. Welch, L. Long, O. Diethelm). The effects of intensive anxiety may necessitate a change in psychoanalytic

technique (B. Mittelmann). A special type of "resistance" may result from such anxiety as well as from resentment (O. Diethelm).

The psychologic study of the growing child by psychopathologically trained physicians has been most fruitful. This type of research is still in its beginning and much can be expected in future years, especially if careful observations can be continued from infancy to adolescence. The concept of regression can be tested in an experimental way. The disorganizing influence of emotions on the growing personality can be determined. The concept of habit-formation can be submitted to a critical scrutiny. It should be possible to get closer to so-called constitutional factors and to those reactions which are now designated by the terms of "character neurosis" and "psychopathic personality." The comparison of the findings of the direct study of small children with those of the same individuals in later life will permit us to determine whether the first few years of life are the ones in which personality patterns and psychoneurotic disorders originate, or whether later life experiences are of more fundamental importance than is accepted at present.

Increased knowledge of the changing personality through adult years to senescence will become the necessary foundation for the investigation of many unclear psychopathologic reactions. Many clinical difficulties which are now hidden behind convenient terms, such as mixed reactions, latent illness, habit deterioration, dementia, will become clearer and will no longer present insurmountable obstacles to clinical progress and to treatment. The progress which has been made in the treatment of the personality disorders of late life has been primarily due to increased psychologic, physiologic, and psychopathologic knowledge of this age group.

3. PHYSIOLOGIC INVESTIGATIONS

Investigations in the physiologic field may greatly enhance the value of psychopathologic findings. They may corroborate the subjective evaluation of emotional experiences. Correlations between physiologic and personality functions offer leads for further well-planned investigations along either line. Several faults have hampered progress. The tendency to consider correlated physiologic and emotional findings in the sense of cause and effect has resulted in ready explanations of involved psychopathologic reactions. The clinician has correlated physiologic findings with clinical entities which themselves have not yet been well defined and described. Frequently, psychiatric investigators have lacked sufficient physiologic knowledge, or physiologically well-trained physicians have not mastered psychopathology. The only satisfactory basis for physiologic studies in psychopathology seems to be a combined type of research in which these two types of investigators work as a team. On the other hand, the shortcomings of cooperative research work are obvious. However, the

mastery of psychopathology and physiology does not seem possible to a degree which will permit critical, independent investigations.

Psychopathologic research in collaboration with pharmacology and organic pathology should prove to be fruitful. Histopathologic investigations of the brain have advanced our knowledge of senile disorders very little. By minute psychopathologic and neurologic observation of senile patients, material can be made available to the histopathologist which will permit him to note concurring psychopathologic and histopathologic changes.

The current tendency to investigate the relationship of emotions to physiologic functions seems justified. However, one cannot conceive that the physiologic study of involved psychopathologic reactions can be fruitful if one refuses to consider the influence of changing emotions upon physiologic functions. Individual reactions vary considerably. In any physiologic investigation, the individual personality setting, the emotions that are present before and at the time of the study, and the psychopathologic setting must be considered. The person's attitude to his body, including type of anticipation of and reaction to pain, must be evaluated. The inborn tendencies of body response as well as of emotional responsiveness and display should be examined. Only with those facts established will it become possible to investigate critically the broader psychiatric reaction type or disease entity.

The value of physiologic investigations in the psychologic and psychopathologic study of anxiety is well recognized. For many reasons psychopathologists have postulated that anxiety represents a fundamental emotion of which fear and tension are merely different expressions. Results of physiologic studies under the influence of varying degrees of intensity and duration of fear, anxiety, and tension have, however, cautioned against accepting the current psychopathologic formulation of anxiety as the basic emotion. Recently, interesting findings have been observed in the study of adrenalergic and cholinergic factors in the blood under the influence of different emotions. The findings relating to prolonged and intense feelings of emotional tension are different from those of anxiety (A. T. Milhorat, E. J. Doty, O. Diethelm).

Physiologic studies have forced us to reconsider the concepts of repression and dissociation. The distinction between the direct influence of emotions and the indirect becomes of great importance. There is the possibility that avenues may become available to study unconscious activity.

In conclusion: the field of psychopathology offers interesting and encouraging possibilities for investigation. Psychopathology is of fundamental importance to clinical psychiatry. The understanding and treatment of personality disorders must be guided by critical psychopathologic consideration.

UNUSUAL ORGANIC COMPLICATING FACTORS IN CONVULSIVE SHOCK THERAPY

A. E. BENNETT, M.D.*

The value of convulsive therapy in affective disorders is fairly well established. The safety of the treatment and prevention of serious complications have been enhanced by the modification of curare. This method has widened the scope of treatment so that many patients with serious organic complications can be successfully treated. It is believed that many more serious disabling affective types with organic disease could be successfully treated. Contraindications for this therapy are exceedingly rare.

I would like to report a few illustrative cases that have been successfully treated to encourage others to expand the treatment where indicated.

Case I—A Jewish woman of 68 for 10 years had symptomatic polycythemia and thrombo angiitis obliterans. In July, 1941 the left great toe was amputated followed by a mid thigh amputation. Severe painful sensation of the entire left leg and toes continued. The patient became restless, insomniac and tearful, "I don't know how I can stand it. Nothing can help me. I would be better off dead." The amputation stump healed but the patient's agitated depressed state became worse and she totally refused to use an artificial limb. On August 20th she was admitted for psychiatric treatment.

The mental status was that of a typical anxiety depression. Her constant preoccupation was pain in the left foot and leg (phantom limb). Psychogenic factors were antagonism against a recent daughter-in-law who she felt had replaced her with her only son.

After eight curare electric convulsions the depression and all complaints of the phantom limb disappeared. The patient became active and learned to walk on the artificial limb. For two years she has remained well adjusted and has had no recurrence.

Case II—C. E., age 50, following 10 years of serious business and family worries developed hypertension. In 1940 two serious attacks of coronary thrombosis occurred and he retired from business to California. His worries only became worse. Agitation and depression progressed to a state of complete invalidism. Four months treatment in a psychiatric sanitarium resulted in no improvement. He then returned home. His somatic delusions caused him to restrict his diet to strained baby foods and he also was taking excessive barbiturate medication for sleep. The mental reaction upon admission was that of acute anxiety, agitation, depression and some paranoid ideas against the family. The physical status of undernutrition, extensive arteriosclerosis and a hypertension of 260/140 were complicating factors.

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After 4 curare electro-shocks the blood pressure was 170/95. Gradually he became interested, ate normally and slept well. After 7 treatments he was markedly improved, then had a slight recurrence and was given 2 more treatments, dismissed in 51 days. This patient has remained very well mentally, supervises his business and has given up his hypochondriacal complaints. He takes regular rest periods; while carrying hypertension of 220/120 he has had no new cardiac attacks.

Case III—R. M., age 33, developed acute manic excitement following operation for a ruptured appendix. Upon admission physical examination showed a fecal fistula and a gaping right rectus incision. He was extremely active, talkative and failed to become quiet with large doses of sedation. The mental reaction was typical of manic excitement with flight of ideas, euphoria and overactivity.

He was placed upon narcosis therapy for 5 days, then the fistula from the ileum and the incision were closed. The excited state continued and 12 days postoperative 3 curare electric treatments were given. The excitement subsided and the patient rapidly gained 13 lbs. in weight and was dismissed fully recovered in 42 days.

Case IV—H. M., age 52, a world war veteran with a psychoneurotic background since childhood had carried a partial disability rating from the war from gas poisoning. He was very successful as an architect until the economic depression, but his marriage adjustment was poor due to partial impotency and autoerotic conflicts.

Eighteen months before admission he developed an acute anxiety depression and remained in the U. S. Veterans Hospital during this time. Because of suicidal attempts he was kept in constant restraint, tube fed and under sedation. He lost 40 lbs. in weight. He was then released to our observation upon request of the family physician.

Upon admission the striking feature was nutritional deficiency—weight 112 lbs. The mental status is best described by his complaint, "There is a terrible force that constricts my throat and lungs, that squeezes the air out of me and tries to prevent me taking another breath. It's all connected with my nerves which are all shot by worrying so much. I guess I worry so and it is the cause of all this. It keeps me from sleeping. I can't sleep without sedatives and they don't help me. Oh, it is too late to help me. I know I will die soon. Every breath takes more strength than the previous one. My worst worry is sleepless nights. They are horrible, another one will kill me . . . etc."

High caloric diet, sub-shock doses of insulin with vitamin B complex were given. No weight gain occurred until after the 3rd curare electro-shock. Then a very rapid gain occurred, 38 lbs. within six weeks time. After the 8 treatments the patient became hypomanic and quite aggressive but cooperative. Ten treatments were given and after 61 days he moved out of the hospital with his wife. He fully recovered with excellent insight and has remained well over one year.

Case V—Mrs. W. R. C., age 37, in December 1942 had developed a marked degree of exophthalmic hyperthryoidism. At this time the patient was very tense, euphoric and overactive. The basal metabolic rate was plus 43. Iodine treatment was given without benefit. January 6, 1943 the B.M.R. was plus 42 but the overactive reaction was so great that she

was admitted to the psychopathic hospital, under the care of Dr. D. C. Burke of Portland, Oregon, with all the characteristics of acute manic excitement. For many days the patient was so disturbed that she slept practically never, and barbiturate sedation was ineffectual. All nourishment was given by nasal gavage, and a rapid weight loss occurred.

In consultation with the surgeons and internists it was agreed the patient's condition was so critical that an operation would be likely to terminate fatally, and if the manic state was permitted to continue it would also prove fatal. Daily spinal drainage and more iodine treatment were tried but without benefit.

On February 23rd, after consultation with me by letter, Dr. Burke started electro-shock therapy and by March 11th eight treatments had been given. Immediate and rapid improvement followed. On March 10th deep x-ray therapy was begun, five treatments of 15 mills. two minutes and 100 roentgens each were given. On March 7, the B.M.R. was plus 63, on March 31st plus 49. The patient relapsed slightly and 3 more electro-shock treatments were given for a total of eleven treatments. On April 6th a thyroidectomy was performed, uneventful recovery followed and the patient was dismissed April 17th. She has remained well since.

We have treated many other affective states with organic complications, most of them successfully, but some without favorable response. A number of patients with cardiac complications and hypertension have recovered from severe depressions. A number complicated with diabetes have responded well. Pernicious anemia with combined sclerosis, Parkinsonism, infantile spastic paralysis, residual anterior poliomyelitis, congenital bone disease, tabes dorsalis, inoperable malignancy, pregnancy, all complicating serious affective disorders, have been treated with curare electro-shock without disaster. However, pulmonary disease, chronic bronchiectasis and decompensated rheumatic heart disease have been aggravated to a point of shortening life by the therapy.

CONCLUSIONS

The modification of curare electro-shock by lessening the severity of the convulsion has enabled us to enlarge the scope of the therapy. Most of the severe affective psychoses complicated by organic diseases can be successfully treated by this method. The only contra-indications in our experience have been active pulmonary infection and cardiac decompensation.

THE EFFECT OF CONVULSIVE THERAPY IN RECURRENT AND RELAPSING TYPES OF AFFECTIVE PSYCHOSIS

A. E. BENNETT M.D.

We have made a study of 103 cases of recurrent types of manic depressive psychoses including another group of affective states that relapsed within 90 days after the administration of convulsive shock therapy. We have compared these groups with a control of 175 single admission cases who have remained well after a similar course of therapy. We have been interested in answering the following questions:

1. Does shock therapy influence the cycle of recurrence of manic depressive attacks?
2. Does shock therapy shorten the attacks or lessen the period of hospitalization?
3. What are the reasons for prompt relapse of certain affective states after shock therapy?

From our study so far we believe it will take a much larger series of cases followed over a much longer period of time to answer these questions, but certain interesting findings that are suggestive have been unearthed.

The recurrent cases of manic depressive psychosis all had previous psychiatric hospital admissions prior to the advent of convulsive therapy. The effect of the shock therapy was compared with the previous history as to length of psychotic episode, duration of illness and as to the effectiveness of the therapy upon breaking up the cycle. The relapsed cases were compared with the control group as to the amount and type of therapy, period of hospital treatment and the type of symptoms in order to ascertain possible causative factors to account for relapse.

Of the control group of 175 single admission cases treated by shock therapy and combined psychiatric treatment—psychotherapy, occupational activities, strict isolation from outside influences, etc.—none have relapsed and they have been followed from 1–5 years, or an average of about 2½ years. 57 of these were involutional depression, 64 manic depressive depressed, 12 manic states, 3 circular type and 39 psychoneurotic or reactive depressions. This group received an average of 8 convulsive shocks and were hospitalized an average of 6 weeks time.

49 recurrent cases included 32 manic depressive, depressed patients, 10 manic states, 5 circular types, 2 psychoneurotic depressions. The 32 manic depressive, depressed patients had previously averaged 2 hospital admissions in which they received symptomatic treatment only. 23 of these (72%) have remained well since shock therapy. 9, or 28%, have had one or more further hospital treatments and repeated courses of shock therapy. The average interval between depressive attacks prior to shock

therapy was 8.8 years in the 9 cases; following shock therapy this interval dropped to 1.9 years. The duration of the depression increased with each attack until shock therapy was given. The average duration of this group of depressions before any hospital treatment was given was over five months. The average duration for the depressive attack including hospitalization prior to shock therapy was 6 months. The average duration of the depressive episode after shock treatment was started was 2 months. Thus, partially answering question 2, shock therapy shortens the duration of the depressive attack by two thirds.

It was interesting in analyzing the sexes in recurrent depressions to find that convulsive therapy successfully prevented recurrences with one hospitalization $2\frac{1}{2}$ times more frequently in the female than the male.

In comparing the number of days of hospitalization and number of shocks given in the successful control group with both the recurrent and relapsed cases, the following facts were discovered. On an average the single admission cases were held 10 more days (42.9 days) than the recurrent and relapsed group (31.9 days). This suggests premature dismissal of some cases as one factor in relapse.

In comparing the average number of treatments given the single admission control group and 54 relapsed cases, the control group averaged 7.2 treatments while the relapsed group averaged 5.5 treatments. Upon return for further treatment they then required an average of 7.4 treatments, approximately the same number as the successful group. This observation suggests a partial answer to question 3, that too few treatments are one cause of failure and it appears that an average of about 8 treatments gives the best results.

An attempt was made to analyze the predominant type of symptoms which were most refractory to treatment. We found the paranoid trends, hypochondriasis, extreme agitation and suicidal tendencies occurred twice as frequently in the recurrent cases as in the control group.

The percentage of full complete remissions was about 10% higher in the control group than in either the recurrent or relapsed groups. Yet social recovery rates were higher in the recurrent groups after further treatment than the control group, reaching 100% in the males, with all failures in the females. These observations suggest that persistence of treatment and followup, getting patients back at the first sign of relapse for further treatment increases markedly the final percentage of good results.

Recoveries as to age incidence showed that the lowest rate of full complete recovery was in the 21–30 age group. The highest percentage of sustained recoveries occurred in the older groups after 60 years of age.

PSYCHOLOGICAL FACTORS IN ASTHMA*

By SELMA LANE, R.N.

The personality structure of persons suffering with asthma has received considerable attention in the literature of psychosomatic medicine recently. This topic is of subjective interest to me, because for many years I have been subject to attacks of asthma. But until I began to study psychiatric nursing in March 1943 and came in contact with people who stress the importance of psychosomatic medicine, I was only slightly aware of the emotional factors involved. From the many case reports and studies available[1, 5, 7, 8] I have attempted to draw the following composite picture of the typical asthmatic patient, to which I shall then append some material derived from observing myself.

The person who suffers from asthma from early childhood has acute feelings of anxiety and insecurity which are greatly accentuated by conflictual situations, or by situations in which he must act independently. He is usually the child of overprotective parents who have constantly guarded him from overexertion or competitive situations and hindered the development of self-reliance in him as a child. He has superior intelligence, especially on verbal tests, with poorer performance ability. In spite of his intelligence, he lacks self-confidence and is very dependent, especially on his mother or on a substitute mother figure. Fear of estrangement from the mother is a dominant but often unconscious characteristic. He rarely expresses his aggressions openly, but gives evidence of considerable latent or repressed aggressiveness. He sometimes has a severe crying spell instead of an asthmatic attack. (The apparent interchangeability of these phenomena has been frequently noted.)

If it can be established that there is a typical personality structure underlying asthma, one must infer that the illness is in part an expression of this character structure and that it cannot be treated solely on the basis of an allergy to certain external factors.

In discussing asthmatic children Weiss and English[1] cite reports made by Strauss[2] and state, "A very large percentage of the children were both overanxious and insecure. This anxiety often reflected the personality of the parents, who in many cases were themselves overanxious and insecure, and therefore would be expected to arouse a similar response in the children. He (Strauss) felt that the asthmatic children fell into two groups: the first were children who had been very much wanted by their parents, such as an only child or the first boy to be born in a family of girls or vice-versa;

* Submitted as a research thesis in fulfillment of the requirements for graduation from the Menninger School of Psychiatric Nursing, February 1, 1944.

while the other group were definitely unwanted children whose parents were overcompensating for their unconscious hostility toward the child."

Weiss and English also cite reports made by Rogerson, Hardcastle and Duguid[3] who worked mainly with children who presented the "asthma-eczema-prurigo syndrome." They state: "Out of twenty-three no less than seventeen of the children were fussed over and overprotected by their parents to a pathological degree. This was not just a slight abnormality of parental attitude; it was pathological to a degree which made one feel that if these children had not been brought to the hospital with asthma or prurigo they might easily have been referred on account of the nervousness engendered in them by this situation."

They summarize this asthma-prurigo personality as follows: "High intelligence on verbal tests with poorer performance ability, marked over-anxiety, lack of self-confidence, considerable latent aggressiveness and egocentricity." These authors (Rogerson, Hardcastle and Duguid) suggest that the anxiety of the children and their parents' oversolicitude may be in part a reaction to the illness. Weiss and English comment upon this as follows: "A severe asthma attack with its acute threat of suffocation is obviously a terrifying experience to both the child and its parents and it is not surprising that children who suffer from asthma should develop feelings of helpless anxiety and insecurity and a tendency to cling to their parents, nor that the parents should develop an overprotective attitude toward them merely as a reaction to the fear of the asthma attacks themselves. On the other hand the examples cited make it plain that in a number of the cases reported in this study the overprotective attitude of the parents existed prior to the onset of the asthma and had also a deeper motivation, such as need to overcompensate for not really wanting the child or fear of losing the only surviving child after several other children had died."

Psychotherapy, which took the form of persuading the parents to be less solicitous and overprotective and encouraging the children to be more independent, was quite successful with a number of the cases, "even when the child remained in the home environment in which the asthma attacks had been severe."

Wittkower[4] gives numerous examples from medical literature of asthma attacks being precipitated by violent emotional disturbances, especially by anger.

French[5] notes that "there seemed to be a very intimate relationship between asthma and crying, or laughing." He compares the asthma attack to the cry of the new born babe and also suggests that "the asthma is really a sort of equivalent of a cry of anxiety or rage which has been inhibited or repressed." He also suggests that "for some reason in the situation which provoked asthma attacks the child was unable to cry." In some of the

treated cases it was observed that as the asthma attacks ceased, attacks of crying appeared in their stead. Such replacement of asthma attacks by crying was particularly apt to occur as insight was gained into the cause of the attacks.

French and Weiss and English agree that there is an acute fear of the estrangement from the mother at the time of an asthma attack. French further says that "closer studies of patients' histories and of their reactions in the analysis make it plain that this acute fear of estrangement from the mother is present not only at the time when the patients have asthma attacks, but also runs as a continuous undercurrent, more or less deeply repressed, throughout these patients' lives. One of the most convincing evidences of this is the behavior of these patients in the analytic situation. . . . It would seem that most patients with asthma are particularly prone to attacks of asthma at times when they are undecided or in a conflict as to whether or not to leave some mother figure."

Wittkower[4] cites a report of Bruegelmann[6] of a patient who regularly had a severe asthma attack at five o'clock in the afternoon, but during an excursion with Bruegelmann one day he missed his regular attack until seven o'clock when Bruegelmann called his attention to the fact. The patient, "hitherto in good spirits, drew out his watch, grew quite pale and a few minutes later began to gasp, sweat ran down his forehead and he was unable to walk another step." French[5] gives another case from Wittkower: "A tobacco saleswoman, hypersensitive for tobacco, regularly had asthma attacks after contact with tobacco. These attacks also occurred when the patient was not aware of contact with the allergen (e.g., subcutaneous injection of tobacco extract). Skin reactions to tobacco were highly positive. By hypnotic order the occurrence of attacks after contact with the allergen could be inhibited. After psychical treatment the patient was relieved of her asthma attacks for a long period. She could be exposed to the smell of tobacco without having attacks. The highly positive skin reaction to tobacco existed unchanged."

French says, "It is well known by allergists that the exposure to an adequate dose of allergen may in some cases be insufficient to precipitate an attack and must in some cases be supplemented by such conditions, for example, as fatigue, emotional disturbances, particular phases of the menstrual cycle, constipation etc. It would seem quite possible therefore that emotional disturbances might play even a very important role in determining the threshold of sensitivity to the specific allergens."

One may ask why, if these facts are well known, so little attention has been paid to the psychological factors in asthma. In my experience in seeking treatment for asthma from many general practitioners, *I have never*

heard one of them mention the possibility of emotional factors causing asthma. They always seem to think that it can arise only on an organic basis.*

The point of view which I was taught in the graduate school of psychiatric nursing and the observations which I learned to make on patients stimulated me to examine my own difficulty in the light of my new insight. In the course of my reading about asthma in particular I found many deductions and observations which were so in agreement with my own history that I was encouraged to set it down.

During my childhood my mother allowed me to be very dependent on her. My first attack of asthma occurred when I was four and one-half years old and followed a slight fall. After this I was subject to frequent attacks, during which I would not accept attention from anyone but my mother. My brother and sister, both younger than I, were superior to me in all games and play from which I was barred by my asthma. They used to tease and provoke me and many times this teasing would bring on attacks. I have often heard my mother say to my brother and sister, "Why don't you leave her alone? You know she will start wheezing." Consequently I spent most of my time in the house with my mother, whose company I much preferred to that of children of my own age.

My attacks seemed to be more severe than usual when they occurred on important occasions. When I was six years old my father died and I had a very severe attack of asthma. After my father's death it was necessary for my mother to be away from home frequently and this was particularly disturbing to me because of my great dependence on her. (I remember that at the age of six I had never dressed myself.) During this period my attacks increased in frequency and severity. One especially severe attack occurred on the day our livestock and farm implements were sold.

The attacks continued after I entered elementary school and often seemed to be related to difficulties I encountered in some subjects. For example, long division was extremely difficult for me to comprehend. Arithmetic class was held in the morning and during the weeks when I was struggling with long division, I frequently awakened in the morning with an attack of asthma which would usually subside entirely by noon so that I was able to go to my afternoon classes. When I spent a night away from home I would almost always have an attack of asthma during the night which would subside when I returned home.

* French[5] says that "the discovery of anaphylaxis and the resultant discovery of the significance of allergic factors in the genesis of asthma tended for a time to draw attention away from the significance of 'nervous' or emotional factors to such an extent that a number of recent asthma monographs hardly mention the possibility of the psychogenesis of asthma or dismiss it as a rare occurrence."

By the time I entered high school at the age of fourteen, the attacks of asthma had become less severe and less frequent. During my first two years of high school I had few attacks and these usually occurred on the days on which I had to give a short talk before a class.

During my junior year in high school I went to live in the home of a doctor. I had always had a chronic rhinitis and at this time it became more acute and annoying. It was usually more severe in the evening than during the day. A sinus operation was performed by an ear, eye, nose and throat doctor. The doctor I lived with administered the anesthetic and the last thing I heard him say as I went under was, "She is so sensitive and cries so easily I think maybe this will help her." There is a possibility that that may have acted upon me somewhat in the nature of a hypnotic suggestion. At any rate after this operation I had very infrequent recurrences of the rhinitis and fewer attacks of asthma; the surgeon was greatly pleased with the result, because, as he said, in a majority of cases these operations are not at all successful. The outcome in my case might be cited as proof that my rhinitis and asthma had a wholly organic basis but subsequent events will indicate otherwise.

During the summer and fall following the operation, I developed hay fever which made its appearance every year thereafter and remained with me for the full season. This stage of affairs continued until this year (1943) when the hay fever started but disappeared after one week. During this time I was working on a men's floor in the hospital. One patient especially bothered me, frequently pointing out my shortcomings by making remarks such as, "You are so sensitive, you will have to desensitize yourself" or "No good psychiatric nurse ever does a thing like that." During this time I became tearful one day and the symptoms of the hay fever subsided. I noticed then that the crying seemed to replace the hay fever!

Reflecting upon this I recalled that during my last two years of high school I did not have any attacks of asthma, as stated above, but I became tearful frequently. If a subject was difficult for me I would cry and decide I would be unable to prepare my lesson and would have to have help from the teacher. At one time I was going to give a short talk in front of my English class. I memorized my speech, thinking that perhaps this would enable me to talk with little difficulty. I stood in front of the room, said one or two sentences, then completely forgot the rest of the speech, and started crying in front of the class. I was tearful the rest of the day. These attacks of crying caused me great embarrassment and despair.

The day I entered training I cried most of the day, and this was repeated many times during my training days, as, for example, when I gave my first hypodermic. I was tearful on the days I spent in surgery, especially when I scrubbed for operations. When I went to another hospital for my affilia-

tion in pediatrics I cried for two days, and again I was tearful for one day when I finished training.

After graduation I worked on the staff of a small hospital for over nine years. Occasionally I had attacks of asthma and occasionally I cried. These two things never occurred at the same time, but they did seem to be precipitated by similar events.

I was tearful when leaving this hospital to take a post graduate course in psychiatry at the Menninger Sanitarium. During my first six months in psychiatry I cried many times in response to certain stresses, such as when I had to give an oral report or read a paper I had written or when anyone said anything to me which hurt my feelings. The last six months, however, I have been much less tearful and I have been able to read the papers I have written before a class.* I have also been a little less sensitive about the things people say to me. But at the same time that this improvement became apparent, I had two or three slight attacks of asthma.

Until I began my psychiatric training, I had never seen any connection between the excessive crying and the asthma. This knowledge, of course, was derived from my reading and was not an original discovery. But to me it was new and helpful. It is difficult to say why a discovery of this kind should in itself bring me a kind of relief. Perhaps it is because I have begun to feel that both the asthma and the crying are ways of expressing myself and since one may be substituted for the other, there may be other less distressing forms of expression which can be substituted when I am in difficulty. The situations which have seemed to precipitate the attacks of asthma and also the crying spells are always those which seem to present insuperable obstacles or frustrations and dangers from which I can not escape. When I am confident of success or am able to express anger, I do not have attacks.

No one, unless he himself has suffered from asthma, can fully realize the actual anxiety that arises during an attack. At times there are fears of death and at other times you wish you could die. And there is always a constant fear of having an attack. I recall many times during an attack striking my mother and saying, "Why don't you do something for me?"

Merely learning that there is a definite personality type associated with asthma and that this type corresponds in many striking ways to my own personality and developmental history, has given me a feeling that something *can* be done through better understanding of the emotional factors.

* In reading this paper to the seminar class, however, perhaps because of its intensely personal character, I broke into tears many times, even though I did not feel the sadness or grief which such a performance suggests to those who observe it. It seemed to serve chiefly as a bid for sympathy, but one out of all proportion to any conscious needs that I felt.

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THE SITUATION VERSUS THE CONDITION IN CONGENITAL SPASTIC PARAPLEGIA

By STELLA McKIBBEN

Editorial Note: The author of this extraordinary paper is a woman of sixty who has been afflicted since birth with a severe athetotic and choreiform spastic paraplegia. During her waking hours she is in constant motion, the right arm and hand hyper-extended, the fingers and hands constantly twitching, flexing and extending, the muscles of the face contracting in involuntary frowns, grins and bizarre expressions, the tongue frequently thrust forcibly out of the mouth, the legs moving irregularly in flexion or extension, the spine curved in a severe lordosis. At first sight she would appear to be completely helpless, although with the aid of various orthopedic devices she is able to walk if assisted by one or two persons, and once seated in a chair or in her tricycle she is able to perform a number of simple tasks, such as pedalling the tricycle or putting on or taking off her spectacles. In attempting to speak, there is such a spasm of the tongue, chest muscles and others that she is almost completely inarticulate, although friends who have been with her are able to put together her monosyllabic sounds into some meaning. She now has a constant attendant because she has never been able to eat a bite unassisted.

For years she has been familiar to the citizens of Topeka, pedalling her tricycle on errands about town unassisted, writhing and grimacing as she proceeded, but still able to smile or nod in recognition of salutations. All of her life, as she says, she was determined to express herself and make people realize she was not an idiot or a fool, unacquainted with human emotions and needs. The discouragement that she received from her own family she steadily combated with a persistency and determination eloquently indicated in the following article. It was when she was past fifty that she finally mastered a technique for tapping out messages on a typewriter with a little plunger invented by herself. Aided by this device, she completed the high school education which had been interrupted for reasons that she makes clear in her article and then had herself taken daily to a local college, attended all the classes, and did all the required work toward an A.B. degree for three years.

She appeared at a seminar of The Menninger Clinic in December 1943 and the following statement prepared by her was read to the staff by her brother. She attempted to demonstrate to us how she did her typing, but the over-stimulation of the audience proved too much for her and she gave up the attempt after a brave struggle, but she told us that this entire article had been written (typed!) by her in one day and then recopied the same day. It is published here with negligibly few editorial changes.

As the reader will see, she puts great emphasis upon the total adjustment problem of the severe spastic patient, calling it the spastic *situation*, and contrasting this with the over-concentration upon the spastic *condition*. She rejects the assumption that the patient's symptoms exist independent of the patient and independent of the reaction of the outside world to these symptoms, and the effect of this reaction upon the patient and upon her symptoms. In other words, this remarkable woman enunciates, on the

basis of a terrific personal experience, the chief burden of modern psychiatric thought, namely, that the patient's anatomy, his physiology, his psychology and his environment go to make up a whole, the interaction of the parts of which are such that no part can be considered alone. The eloquence of this message is referable to the unique circumstances under which it was composed and delivered; the editors feel that no one knowing these can read it unmoved.

My Friends,

I should like to embrace my present opportunity to talk to the specialists about the spastic situation and what is to be done about it. In so doing, however, I must type what I have to say, since I do not speak plainly. Again, may I ask that you read what I have to say while I am with you that I may study how to put things across to you. I can only tell you what I have learned by experience as I learn how to put it across to you. I prefer to be very careful here.

My life story could be of little interest to anyone, but what I have learned by experience as a complete spastic will prove of vital interest.

When first I remember to have awakened to life, I sensed the disturbed thought of my mother who had a very strong will and yet a fearful heart. I very keenly felt the need of her constant and loving care, and yet her intensely anxious and troubled thought made me more uncomfortable than did my inability to lie still. For this reason I wanted her near and yet wished she would go away. My worry over my inconsistent state of feeling daily increased the jumping of nerves and contracting of muscles, and so up ran my fever which caused me to drink two quarts of water per day, and thank goodness, mother gave me all the water I wanted. I was about five years of age when I noticed that my sister, who was younger than I, did not have the spastic situation to suffer as I did. Folks on the street did not make silly remarks about her. Why? She was not like me any way. She was a good little girl, but I was just as bad as bad could be. I was willful, brave, and I laughed every time father said, "damn." Sister would not do that.

I could run just as fast as she could, but why didn't I do it? In other words, I had conscious power of accomplishment, but no physical freedom of expression.

My great Uncle Winslow took my case up with the specialists in Europe, whatever my case was. Why, I was not sick! I was so well that I could feel life running races with itself all the way through me. I was so full of life and fun that I could not even behave myself all the time. Anyway, I was not going to do it.

My sense of decency was outraged when my parents stripped me of all my clothes and had my picture taken that way and uptown at that. Be-

cause I kicked and screamed in rebellion, my mother spanked me. Hence at the time that picture was taken my whole body was in a state of very strong and resentful emotion as well as in an extreme state of spasticity, and so the picture was so untrue of both me and my spastic condition as to strike those specialists with horror. They wrote that my case was hopeless.

Believing me to be in pain, my great uncle wanted to make me a gift and asked me what I wanted. When I finally made it understood that I wanted a big two-seated lawn swing my mother said it was a most "absurd notion" for I could not even sit up in my chair five minutes at a time without falling over sideways so far that she had to sit me up again. Uncle said that since I could not live long anyway I should have what I wanted and so he gave me the swing. Father sat in the swing with me on his lap. Mother who was in the house screamed. Father sat me down to go to mother and upon his return found me with my arm around a rod which ran up the side of the seat so I would not fall over to one side, and swaying my swing just a bit by bobbing my head back and forth. "You think you are smart, don't you?", father said in a derisive tone, and then he sat in a chair nearby and read his daily newspaper as if he had forgotten my very existence. This was the best of parental attitudes under the circumstances. By playing in my swing all summer I so strengthened my back that I have been able to sit up all of every day since that time. I overheard my father ask my mother, "How did that little devil know her need of that swing?"

After that my parents bought me everything I asked for without voicing any question, and forced themselves to remain silent while I used what I had asked for as a tool of operation in my determined efforts of physical accomplishment. This was all that they knew to do about helping me meet my barriers to progress, for, like most folks, they believed all my barriers were physical ones; whereas they needed to know that it is the spastic situation rather than the spastic condition which presents the greatest barriers to progress in every case of severe spasticity when the mind is sound.

To explain: Is a man necessarily an idiot, when his tongue has been cut out, leaving him no intelligent expression of thought? No. Neither is the complete spastic necessarily void of personal worth, even though his body has been injured so seriously as to make no proper response to his will of accomplishment. Were the complete spastic thus understood, there would be no spastic situation. As it is, however, ignorance causes people to look to the body for the expression of self in the spastic case, just as they do in the case of others, and not finding it, they conclude the severe spastic has no personal worth. This conclusion provokes abnormal concepts and

malassumptions both grievous and many. This is the beginning of the spastic situation.

Believing the child to be very ill, his parents consult a doctor. As a rule, doctors know nothing about the spastic condition, and so talk at random about the child, because they must entertain these parents, by way of retaining the confidence of family and friends upon whom their popularity and success as doctors largely depend. The one thing they always succeed in doing in the spastic case is to talk repeatedly at random about a superfluity of nothingness until these parents are so full of abnormal concepts of their child that they become panic-stricken.

The mother seeks relief in talking about the child's condition and about what this and that doctor told her. Idle gossip repeats everything the mother has said, adds its own opinions, and then runs into bitter criticism. Then this mother tries to talk them both down and to silence them by attempting to adjust the spastic youth's life regime to suit the general drift of thought, regardless of the fact that such an adjustment could not possibly be made. The reaction to this is that this mother throws herself into a state of nervous collapse.

The father has done everything possible to find help for his spastic child in the medical world, and in so doing, he has spent all he has saved, earned, and could borrow. Then losing faith in his own best judgment, he has decided to leave the question as to what is best to do for the child up to the womanly intuition of the boy's mother, and then back her up in whatever she decides to do. Now, however, something must be done. The mother is ill and the father at his wits end. Both are mental jitterbugs.

Such is the spastic situation and the parents' involvement in it, stated in general. To the complete spastic of intelligence, the spastic situation is a pandora box out of which comes a host of atrocious impositions to be inflicted upon him. For example, social ostracism would rob him of home, of contacts with his fellow beings, of school, church, of his own personal rights and possessions, and of every other vital thing which means life to the intelligent human being. Thus it would increase the jumping of nerves beyond human endurance and contract muscles so painfully tight that bodily parts ache.

Not understanding these great barriers to progress in the spastic case and not being willing to pause to be taught, is it any wonder that doctors do not actually help in the spastic case? They hope to, but there is no permanent improvement.

During all of my childhood, other children liked me because I was full of fun and mischief, so they included me in their play and took me with them everywhere they went. Hence at the sensitive age of sixteen, I was wholly unprepared for the first appearance of social ostracism which con-

trolled the grown folks' tongues. I could no longer go to dances with the other young folks, and sit on the sidelines and watch them as I had always done before, and so on with restrictions I had never had before. My great concern was whether or not I could stand alone in refusing to accept a maladjustment of my life regime, on the basis that I was no more a spastic than I had been before, and so no cause for a maladjustment than there had been.

Must I submit? I asked myself, and then I knew that my perfect general health and sound mind would never succumb—NEVER. For years I struggled and suffered, because as there was no one who knew how to help me, I had to learn by experience what the spastic situation was and how to escape the devilish things it would impose upon the severe spastic.

The fact that there were as many abnormal concepts of me and of what my life regime should be as there were people to form them proved that I could not, and so did not have to conform to any of them. So there was nothing to prevent me from living a normal life as a grown up and just as I had in childhood, so far as I was physically free to do so. I also discovered that the inconsistency of human nature affords one a way of escape from those things which social ostracism would impose.

This discovery had to be made before my opportunity to graduate from high school, go on to college, and work in Dr. M. E. Pusitz's (orthopedic) clinic came my way. At the clinic I had a very long table with six typewriters on it. I had two of my fourteen spastic pupils sit on either side of me while I gave them a lesson in English by use of my typewriter, and then I sent them to the other end of the table to type their recitation, while I gave the next two of them a lesson. In my three years' work at the clinic, I came into daily contact with my pupils and their parents and thus found that my views upon the spastic situation were confirmed in every conceivable way.

In the mild cases of spasticity, the spastic has enough use of his body in expressing himself to have a normal approach. Hence, his personal worth is not seriously underestimated, and therefore there is no spastic situation to impose upon him. The less such a spastic knows about the spastic situation, the more readily he can ignore the shadow which it casts his way, and to ignore it is the right thing for him to do. In fact, one bite off this tree of knowledge does this spastic and his parents more serious damage within five minutes than can be corrected in many years, so susceptible is he to the least suggestion that he should not count himself as being one with other people, and so ready are his parents to insist that he act upon such a suggestion.

The reverse is the case of the severe spastic and his parents, for the more they know about the spastic situation as being a situation and understand

how to deal with it intelligently, the better off they are—the less of mental jitter-bugs these parents are, and the less severely the spastic's nerves jump and his muscles contract.

Proper physical exercises, the mind kept busy with school work and instructive lectures on the spastic situation and how to deal with it advantageously is the crying need in the spastic field of labor.

When specialists understand the spastic situation and how to deal with it from the viewpoint which I have just presented to you, they will give these parents, who sooner or later all become mental jitter-bugs, proper and periodical hospitalization, and you will see to it that lecture courses of study on the spastic situation and the corrective attitude to take towards it are given from the parental angle to these parents, and that complete spastics are given a course of lectures in regard to what the spastic situation is and how to escape the things it would impose.

Such lectures must place the subject on the positive and objective viewpoint and hold it there. Only able lecturers like Karl, who understand the psychological workings of the human mind as he does, are fitted to give these corrective lectures on the spastic situation. You know best how to guard this point, and it certainly must be guarded with great care if we improve matters instead of making them worse. If you wish, I could give you a few examples of what such lectures would be when next we meet.

I thank you for giving me this hearing.

PSYCHIATRY AND THE ARMY*

By COLONEL WILLIAM C. MENNINGER, M.C.

It is an honor and a pleasure to have the privilege of speaking to this illustrious group, but I feel that the opportunity carries very heavy responsibilities. First, I must represent, and wish to briefly present the organized psychiatric efforts of our Army; second, I regard it an unusual opportunity to discuss with you some vistas and challenges to all organized psychiatry, and many of them specifically to psychoanalytically oriented psychiatry, that are presented in this global war; and third, I feel it is obligatory to call your attention to some challenging needs toward which we in psychiatry must immediately direct our efforts.

It was the brilliant Thomas W. Salmon, Chief of Psychiatry for the Army in the first World War, who drew the analogy between psychiatry and Cinderella as the result of that conflict. Until 1917, the practice of psychiatry had occupied a relatively inconspicuous back room in the field of medicine. In part because of the acute need, and in part because of the brilliant work carried out by our military psychiatrists at that time, our specialty rather suddenly came into the limelight and took its place among its sister specialites of medicine and surgery. The impetus from the present war to the growth and the recognition and the unlimited opportunities of psychiatry will be far greater than that which occurred in 1917 and 1918. We are a part of a cataclysmic movement that is going on now, at this moment. It is simultaneously our responsibility and opportunity. Circumstances demand that all of us must live under great pressure and many of us under considerable strain. Our daily program is filled with many details, many trivia, so much so that rarely do we have a moment to pause and take stock of the major issues, the opportunities that confront you and me, and all organized psychiatry.

First, I want to pay tribute to our psychiatrists in the Armed Forces, hundreds of them scattered all over the world, carrying on as individuals or in very small isolated groups of two, three, and once in a long while, four or more. Nearly 26% of the membership of the American Psychiatric Association are now in the Armed Forces, and there are nearly an equal number of men, less well-trained in psychiatry, who, in some instances by choice and in some instances by command, are working in this field. This group is carrying on in a splendid fashion and, in many instances, under great difficulty.

*Delivered before the American Psychoanalytic Association, Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, May 15, 1944. Approximately simultaneous publication of this address in PSYCHIATRY is by arrangement of the respective editors.

We can justifiably feel proud of the contribution of the members of the American Psychoanalytic Association. In doing so, I do not want to imply that in any way our members are any better than the rest of the psychiatric group. I am proud of the fact that more than forty members of this organization are in the Army or the Navy. The average age of the membership of the American Psychoanalytic is probably much higher than the average of the American Psychiatric. Consequently, forty men from this small organization is a significant contribution. I am not too familiar with the functions and positions of our members in the Navy, though I know many of them hold positions of distinction. In the Army, three of our eleven key men, the Service Command and theater consultants, are members of this organization: M. Ralph Kauffman, Lauren H. Smith, and Henry W. Brosin. One of our members, John M. Murray, is the chief psychiatrist of the Air Force, and his right-hand associate, Roy R. Grinker, is in charge of one of our most important treatment centers in the Air Force. At least three of our members are functioning in the extremely important job of psychiatrist in the consultation service in our basic training camps, the replacement training centers. Three other members are chiefs of the psychiatric services in named general hospitals. Many are carrying on in the overseas theaters, in hospitals and in divisions.

Very possibly you are familiar with the method of practice of psychiatry in the Army. One of its greatest compensations is the intimate association with the other specialties in the field of medicine and the close cooperation between the psychiatrist and his medical confreres. Throughout the military forces our doctors work in groups; rarely alone. More accurately one may say that they work in teams, hospital teams, dispensary teams, regimental and divisional teams, and there is an intimate shoulder to shoulder relationship between the surgeon, the internist and the psychiatrist. Undoubtedly one of the most important after-effects of this team work will be a better understanding among the members of this team, understanding of each other and understanding of the work in their respective fields. There is no doubt that the psychiatrist is learning much about medicine and surgery, and the military situation is requiring that the internist and surgeon learn much about psychiatry. What they may learn, however, depends very largely on the psychiatrist associated with them.

In civilian practice psychiatrists have probably isolated themselves too much. There is no doubt that psychiatry contains its full share of individuals with conspicuous eccentricities and peculiarities, many of them undoubtedly having sought psychiatry as a form of self-help. One may go further and say that probably the analytic group has even a higher percentage of "unusual" individuals. Because of the intimate association

of the group of medical officers within our Army hospitals and the necessity for close team work, the internists and surgeons are keenly aware of the type of individuals who carry out psychiatric practice. I am tremendously impressed with the grand job that many of our psychiatrists have done in presenting psychiatry to these men in the other fields of medicine. One very often hears the psychiatrist described as "practical" or as "sensible," or as "having his feet on the ground." On the contrary, the most unfortunate results occur when we have an eccentric psychiatrist. A specific instance in my brief Army experience will illustrate this. The individual I have in mind had had analytic training, but fortunately was not a member of this organization, even though he probably aspires to membership. This man was always trying to explain to the chief of medicine and the other medical officers that the chief difficulty in most patients was due to the "oedipus conflict." Occasionally, he would ascribe the patients symptoms to the "castration complex."

While perhaps humorous, this problem has a very special significance to us in the analytic group. One such silly interpretation can undo the patient work of many of the rest of us, and prejudice a countless number of people against the whole field. This is an exaggerated instance, but it should give us cause to inspect the possible basis in our relationships that perhaps more subtly fosters the same prejudice. In the first place, there is little doubt that too many analysts isolate themselves from all other medical groups. They are conspicuously absent from academies of medicine, from country medical societies, from state medical societies, from participation in general hospital staff meetings. Through some sort of self-destructive tendencies, we tend to keep whatever we have to give among ourselves, and, unfortunately, if we do try to present our ideas to other groups, we too often make the sorry mistake of using some incomprehensive jargon which calls forth the frantic efforts of our confreres to escape. One unfortunate immunization makes them impervious to all subsequent attempts at innoculation.

Further scrutiny reveals certain other facts that lend to the truth of the opinion about the impracticability of many psychiatrists and particularly analysts. There is no direct opportunity to use analytic methods in the Army (perhaps it would be more literal to say analytical techniques), and yet analytic understanding can be universally applied. Too many analysts have had neither sufficient medical experience nor psychiatric experience to know what the score is, and once analyzed, they specialize in psychoanalysis to the exclusion of both medicine and psychiatry. An analytic experience, except for therapeutic purposes, without a medical and psychiatric foundation is a house built on sand. This brings up the fundamental question as to whether psychoanalysis is a medical discipline or

whether it is not. If it is, and we regard it so, we can certainly win the confidence and interest and support of our medical confreres. If it is not, then we cannot.

What is being done in the field of psychiatry in the Army? Everyone who is in the structure of the Army, both medical and line officers, recognize the psychiatric and mental hygiene problems as being very extensive, and perhaps one of the most important problems connected with any Army. Its ramifications are difficult of comprehension. Its implications are present in every stage of every man's contact with the Army. It begins with the selection of the recruit, a complicated process if done adequately. As soon as a soldier goes into training, having left his home, his job, and his friends, he is confronted with a major readjustment in the acceptance of the new job, the regimentation, the discipline, the strenuous program. When it comes time to go overseas, he is confronted with a new set of problems. When he gets overseas, depending on his location, he is confronted with more extremely difficult readjustments, with the new additional elements of terrain, climate, isolation, monotony. Always there is the waiting period for action, another tense and difficult experience. Combat presents an entirely new set of psychiatric problems. And finally, there are the men who return.

No doubt many of you know, in general, of some of the things that have taken place in the field of psychiatry to meet these problems in the Army. A brief resume may be of interest to you. When the war began, the majority of the psychiatrists in the Army were connected with hospitals. A few were stationed in induction centers. The need for prophylaxis and preventive psychiatry gradually became more evident. In 1942 a psychiatrist was placed in each of our basic training camps, called replacement training centers, where he set up a mental hygiene clinic. Late in 1943 a psychiatrist was assigned to each combat division, both armored and infantry. In both of these situations the psychiatrist's chief function is preventive psychiatry and an opportunity to help the maladjusting man rather than the maladjusted man.

Within the last few months there have been many new developments. It was possible to obtain approval and obtain a directive that all officers, both medical and line, should be given some lectures in mental hygiene, and the bulletin which was subsequently published outlining these would be of special interest to this group because of its definite dynamic orientation. In addition, three hours were authorized in mental hygiene for all enlisted men and a bulletin has been published outlining these lectures. A treatment directive, indicating methods and techniques, was issued to cover treatment in combat areas, and very recently an outline of treatment to be carried out in hospitals has been issued.

One of our major problems has been the necessity to salvage men, salvage them for the Army and salvage them for their return to civilian life. One very successful project was undertaken in the establishment of some experimental retraining units within replacement training camps, composed of a battalion of trainees who were psychoneurotic patients taken from hospitals. These efforts have been successful in salvaging between sixty (60%) and eighty (80%) per cent of the men so retrained.

We have been, and are, faced with an acute shortage of psychiatrists. Since January 1943 a school in military psychiatry has been in operation, giving a one month course for students who had had some previous orientation in psychiatry. Beginning in April of this year, a three months' course was initiated at Columbia and at Bellevue, in addition to the school run by the Army at Mason General Hospital, for medical officers without previous psychiatric orientation. It is perhaps of special significance that, with the exception of some training given at the Mayo Clinic, this is the only course given by civilians for medical officers in the Army.

Certain changes have been made in the induction center neuropsychiatric examination. We hope these will be of far reaching benefit to both the selectees and the Army, and certainly they are a very definite forward step from the point of view of psychiatric practice. We have made some contacts with the training group and with the personnel division of the Army. It has been possible to have psychologists included in the table of organization for all overseas hospitals, and plans are under way for the assignment of a psychologist to the neuropsychiatric section of our larger hospitals in this country.

It will be of interest to know that neuropsychiatry is now a Division in The Surgeon General's Office on an equal par with medicine and surgery. There are six of us in the office, one of whom is a neurologist, one of whom is primarily responsible for liaison with the morale and orientation services, and the rest actively planning and supervising the psychiatric work. It was possible to have appointed as Consultants to the Secretary of War the special War Committee of the American Psychiatric Association and also a representative of the American Neurological Association.

While this recitation of activities may be of interest to you, and may be news to a few of you, I should like to suggest some of those vistas of opportunities that lie before all of us in psychiatry as a result of this war. The whole world is being shaken in an acute psychosis and it is our opportunity, in fact, our responsibility to study this psychopathology, to attempt to understand it, and make heroic efforts towards immediate therapy and plans for future reconstruction. The problem is here and it is our opportunity to organize ourselves to meet it and contribute to the solutions.

This war will probably bring about a reorientation in our methods of quick evaluation of the individual. We must suspect from our experience to date that our methods, and probably our knowledge, are inadequate to evaluate a personality. Our psychiatric examinations in an induction center, while unquestionably of very great value, consist chiefly of impressions. This is not due merely to the lack of time or to the lack of information. Presumably we wish to select men who can stand the stress of military service. There are many that can be eliminated with positive assurance. Others are on the borderline in which rejection or acceptance depends on the attitude of the examiner. There are some who, even with adequate study, we believe should be able to make the grade within the Army, who on trial prove us to be wrong. Most confusing are those who despite their neurosis or neurotic acting-out, make excellent soldiers. Other soldiers who have developed into psychoneurotic casualties have been decorated for bravery in action. It is an intensely interesting and challenging fact that studies are indicating that a considerable number of soldiers, who have gone through even the stress of battle, have histories of neurotic difficulties and many come from broken homes or other equally traumatic childhood experiences. On the other hand, some neuropsychiatric battle casualties give no previous history of neurotic maladjustment. We have an unparalleled opportunity to study the effective methods for selection, at the moment selection for the Army and how the man adjusts to the Army. The facts we may learn may help us pass the stage of acting merely on impressions, and the possibilities of the application of this knowledge to the selection of men for vocations, in industry, in business, in professions, is unlimited.

Never before have we had so extensive an opportunity to observe how the personality functions under stress. Millions of men have left the established security of their homes, of their jobs, of their friends, and they have been "forced" into a new and strange life, and a strange environment and a strenuous job. What are the factors that aid the man in his adjustment? What are the types of decompensation that he shows? We are familiar, already, with men who develop the functional somatic difficulties. There is no richer field for research than the psychosomatic, including the factors determining the selection of the organ which the individual chooses for the expression of his symptoms.

As psychiatrists we are fundamentally interested in motivation. In the Army, we are confronted with the problem of motivating the man to want to fight. This motive must be strong enough to make him give his life, if necessary. He must reverse all his previous moral and ethical teachings in order to be able to do so. How should this be done? What are we learning from the way that it is being done? How can it be applied in constructive ways after the war?

Never before have we had such rich opportunities to study therapy, to study mass education. This opportunity not only exists within the Army, but is already widely available in civilian life. One of psychiatry's great limitations has been the fact that it could not reach the masses despite the fact that the masses needed help. Of all the highly individualized treatments, psychoanalysis has probably the widest applicability and the lowest availability. How can its principles be applied to a group? Not only do we need this knowledge for its use within the Army, but we should provide it for the increasing need in civilian life.

The problems with psychiatric complications following the war are too numerous and perhaps too large for me to more than speculate about. Can the culture of a race, the Germans for instance, be changed? How can inter-racial hostilities and fears be bridged? How can nationalistic aggressiveness be best directed and controlled?

All these and many other problems lie in front of us. Many of them are directly related to the Army situation and, thus, may not be immediately available to this group for study. Consequently I should not lose the opportunity to call to your attention certain specific ways in which the civilian members of this group can participate in the problems at hand. Long since we have all been forced to the recognition that everywhere we are short of manpower. That applies with great specificity to psychiatry, both within the Army and out of the Army. It has made it absolutely essential for those of us in the military service to lean upon and call for help from our confreres in civilian life in many ways. I should like to take this opportunity to point out certain ways in which this group can very definitely become involved, if it wishes to, individually or collectively, in major undertakings quite apart from those cited above.

1. PUBLIC EDUCATION

Never before have we so needed public education to present the psychiatric point of view of various features of the present emergency. The large number of men that are rejected at our induction centers for personality disorders present a very special problem in the community, not only for the man and his family, but equally well for the community. Too often the man in some way or another is regarded as stigmatized, and if ever this unjustified, unreasonable attitude is to be changed, it must be done through education of the public by the psychiatrist. The men discharged from the Army for neuropsychiatric difficulties come home to a cloud of misunderstanding, or at least to a woeful lack of understanding. Again, if this situation is going to be changed, it must be through the concentrated and intensive action of psychiatrists. The public, the press, and the radio are clamoring for the guidance that our group can give. Within the Army, we have the responsibility of directing our entire efforts toward

winning the war. As much as we know this reorientation of the home front needs to be done, we have had to turn down many requests for talks and for magazine and newspaper articles on this subject. Often we have attempted, sometimes successfully, to refer such requests to our civilian confreres. Psychiatry is "missing the boat" if it fails to make an organized effort in this direction.

2. CLOSER PARTICIPATION WITH MEDICINE AND SURGERY

As I indicated above, never have I had such a delightful opportunity to work so closely with the other fields of medicine. In many instances, I have come to regard myself as something of a salesman. The problems of psychiatry in every hospital are enormous, and every gastro-intestinal ward, every cardiac ward, every orthopedic ward, has a large number of psychiatric patients. Every such instance has been an opportunity for the psychiatrist to be an educator, to sell a bill of goods in the form of an understandable and helpful psychiatry. But in this job I have been repeatedly and keenly aware of the failure of psychiatry to be well represented. We have had too few psychiatrists who seemed to be able to present their knowledge and suggestions in terms which the internist and surgeon would or could grasp. In part, I think it is our own tendency toward isolation; in part, it is because of a needless use of psychiatric jargon in such situations; in part, it has been an indifference on the part of psychiatrists toward general medical and surgical problems. It is my earnest hope and recommendation that in some organized plan, this organization should recognize and attempt to meet this opportunity.

3. LEADERSHIP IN OTHER FIELDS OF HUMAN BEHAVIOR

Perhaps it is a narcissistic illusion that others may not share, but I firmly believe that psychiatry has a great deal to offer to large fields of human activity, such as education, industry, recreation. My Army experience of working with men in the field of personnel, with men in the field of training, with men in the field of morale and orientation and motivation, has made me keenly aware of these opportunities. With good justification our parent organization, The American Psychiatric Association, has standing committees on psychiatric nursing and on occupational therapy. Why not, however, have standing committees on these much wider and broader fields—the fields of industrial psychiatry, of psychiatry as applied to education, of psychiatry as applied to the leisure time activities of man, recreation? I don't mean to imply that I think we have all the answers to the questions in any of these fields, but I am firmly convinced that we could contribute. This contribution would be greatest in those rare

instances where the psychiatrist had actively participated in community leadership or had had a special interest in recreation or industry or education, enabling him to know the problems in those fields. Why shouldn't our organization have some way of pooling such interests, such knowledge? Is there anything forbidding the utilization of the brilliance and the experience and the interest of the members of our psychoanalytic group in these directions?

4. POST-WAR TRAINING OF PSYCHIATRISTS

Everyone knows, who has any knowledge of the subject at all, that psychiatrists will be in even greater demand following the war. An inevitable result of this holocaust will be the increased needs for psychiatry with a multitude of opportunities for psychiatrists. Just as the last war emphasized the importance of this field, this present war will certainly even further increase that importance. There are medical groups tentatively formulating plans for post-war training of doctors. Are the psychiatrists represented in this group? Are we in psychiatry asserting our leadership in formulating plans in this direction?

It would be my hope that the American Psychoanalytic Association might take cognizance of this need and formulate some definite plans as to its contribution. I believe we would be united in our belief that a psychoanalytic orientation is of tremendous value in the armamentarium of the psychiatrist. God forbid that we should verge any closer to the "holier than thou" attitude manifested by too many psychoanalysts towards the man without this training. Over a period of years in our own clinic in Topeka, we have had a number of psychiatrists who have never had an opportunity to have their own analyses, but who have profited immensely from an analytic orientation. The work of the Washington colleagues in the same direction is highly commendable. Will we have the good judgment to recognize this need and our opportunity? Certainly if such training is to be supplied, it should be through our leadership.

5. POST-WAR PSYCHIATRIC PROBLEMS

To forecast the immensity of the job of the psychiatric aspects of rehabilitation, is beyond my wildest speculation. The amount of money and misery that it will cost is beyond calculation. A major hope is an effective and prompt united effort through the leadership of psychiatry. But only through efficient and immediate planning, not a year hence or after the war, but right now, will we in any way be able to reduce the cost. What group can be expected to understand or grasp as clearly the attitudes of the readjusting community membership which we can confidently expect, the aggressiveness, the hostility, the passivity, the subtleness of the second-

ary gain of a neurosis, the bungling system of pensioning an individual to stay sick? If the public is to be prepared, if facilities are to be planned, if a treatment program is to be carried out, who has a greater responsibility than organized psychiatry? Is this Association going to have any plans formulated?

6. OUR MEMBERS IN THE ARMED FORCES

Last but not least, I want to make an appeal for our membership in the Armed Forces. Our membership is scattered from India to Italy and in almost all cases they are functioning in isolated situations, almost surely with no other analyst to talk to, and very possibly without another psychiatrist to talk to. I have no doubts whatever that the question must occur to many of them as to whether this organization ever thinks about them, and if so, what does it think about them? Has it ever attempted to contact them in any systematic way? Has it ever attempted to send them any sort of literature which they crave? Has it in any way attempted to establish a personal contact with them? Has it given any thought to their post-war opportunities for training and practice? They are out there fighting your war and mine. Have we as an organized group given them consideration?

With these questions I'll close, thanking you for the honor of inviting me to speak and giving me the courtesy of listening to me. If I have succeeded in disturbing the atrophied super-egos of a group of analysts in even a small degree in the direction of crying needs, I shall feel repaid.

BOOK NOTICES

William Henry Welch and the Heroic Age of American Medicine. By SIMON FLEXNER, M.D., and JAMES THOMAS FLEXNER. Price $3.75. Pp. 539. New York, The Viking Press, 1941.

Partly because of his personal charm and friendliness, partly because of his sound judgment, partly because he was born at the right time and met the right people, and partly because, as a bachelor, he devoted himself with a prodigious singleness of heart to Johns Hopkins University and to the teaching of medicine, Dr. Welch attained the unofficial statue of "Dean of American medicine." This is a competent, well written biography of him by another Dean of American medicine, Simon Flexner, and his son. (K. A. M.)

The Unemployed. By ELI GINZBERG and associates. Price $4.00. Pp. 418. New York, Harper & Bros., 1943.

This is a psychological study of what unemployment does to people. It is a description, with some interpretation of the reactions of the unemployed before and after they obtained "relief." It is documented with case studies of twelve families. The book is excellently written and conveys with a feeling of complete validity a very definite picture of the emotional stresses incident to the social disease of unemployment. (K. A. M.)

The Structure of Morale. By J. T. MACCURDY. Price $2.00. Pp. 224. Macmillan, New York, 1943.

The book is a compilation of the author's lectures on psychological problems and morale to officers and men in the British armed forces.

In examining the reaction of fear, the writer shows that German token bombing early in the war stiffened British morale by teaching people how to discriminate among signals and how to protect themselves from actual danger. Similarly, evacuation of civilians harmed morale, while sticking to the job along with proper protection improved morale. It is therefore psychologically sound not to hit the enemy until one can hit hard and almost continuously.

Dr. MacCurdy analyzes national scales of values of Chinese, Japanese, Russian, German, Italian, and British peoples to determine which activities stimulate and which depress morale.

The author believes that German civilians, necessarily subjected to longer strain and deprivation than the military, are gradually reaching a limit of the will to sacrifice, as shown by greater susceptibility to infection, decreased working capacity, and longing for relief from strain. "Hitler's phobia of a breakdown at home is likely, as so many delusional ideas are prone to do, to validate itself in a perverse way." (B. S. E.)

Psychiatry in War. By EMILIO MIRA, M.D. Price $2.75. Pp. 206. New York, W. W. Norton and Co., 1943.

Mira was the Professor of Psychiatry at the University of Barcelona, the Psychiatrist-in-Chief of the Spanish Republican Army, and he is now lecturer in psychotherapy and medical psychology at the University of Buenos Aires. This book is an expansion of the Salmon lectures in 1943.

Specifically, it contains an excellent discussion of applied psychology and psychiatry in the military forces and in war conditions. Most of this material represents an excellent organization of the rich experience of a wise and competent physician. (K. A. M.)

Maternal Overprotection. By DAVID M. LEVY. Price $4.50. Pp. 417. New York, Columbia University Press, 1943.

This is a highly interesting compilation of over 2000 case records that attempt to show the problem of maternal overprotection, its dependence upon emotional, physical and social factors from every conceivable angle. The findings are discussed from the psychoanalytic point of view and wherever possible, evidence from animal experiments is given to support the clinical and theoretical data. Because of its wealth of carefully and often dramatically described cases, the complete survey of pertaining literature and the original theories of the author, this book should be required reading for child psychiatrists, social workers and educators. (F. J. H.)

Expectantly Yours. By MARIO A. CASTALLO and AUDREY WALZ. Price $1.75. Pp. 110. New York, Macmillan, 1943.

Expectantly Yours presents with a lightness but directness the physiological facts desirable for a pregnant woman to have in order to stimulate early her "alert cooperation" with the obstetrician. For the well-adjusted intelligent woman, we would expect the book to accomplish its purpose. For the woman with a tendency to be anxious or neurotic about her condition, the emphasis on the need to keep in touch with her physician and the anticipation of things ahead may focus more anxiety at one point than the obstetrician intended.

The psychological aspects of pregnancy and delivery touched upon are a valuable contribution to the book, but the last chapter about the mother's attitude toward the new baby is a disappointment. (L. C.)

Principles and Practice of Rehabilitation. By JOHN EISELE DAVIS, M.A., Sc.D. Price $3.00. Pp. 211. New York, A. S. Barnes, 1943.

The author foresees a steady increase in mental illness in the next twenty-five years due to the social and economic readjustments following the war. He stresses the importance of rehabilitating patients not only in the economic sense, but in a broader social sense as well. He recognizes the complexity of the problem which will require close cooperation among "the educator, the psychologist, the psychiatrist, the vocational and recreational specialists, as well as the placement advisor."

Psychiatric and psychoanalytic approaches to the problem of rehabilitation are discussed. The author emphasizes the importance of clinical testing. (J. W. M. and K. W.)